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	17E183	A. BUILDING _____ B. WING _____	08/19/2014

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigations #75650, #77189, #77190, #77193.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on record review and interview, the facility failed to	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 278	Continued From page 1 accurately assess and code the (MDS) Minimum Data Set 3.0 assessment for 1 sampled resident. (Resident #16 for weight loss) Findings included: - Resident #16's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 8/6/14, indicated the resident scored 9 on the (BIMS) Brief Interview for Mental Status, which indicated moderate cognitive impairment, and required extensive assistance of 1 staff for most (ADLs) Activities of Daily Living. The MDS indicated the resident weighed 133# (pounds), had a weight loss of 5% or more in the last month and received a mechanically altered diet. The quarterly MDS, dated 5/14/14, was unchanged except for the resident weighed 130#. Review of the medical record indicated the resident's weight on the following dates: 7/28/14-133# (prior to the 8/6/14 MDS) 5/9/14-130# (prior to the 5/14/14 MDS) Which indicated a weight loss of 1.5% and not 5%. On 8/7/14 at Administrative Nurse A verified the resident did not have a 5% weight loss on the 8/6/14 and it was an inaccurate entry. The facility failed to accurately assess Resident #16 for weight loss on the quarterly MDS dated 8/6/14.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280		

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F 280	Continued From page 2 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on observation, interview and record review the facility failed to revise the care plan for 4 of 17 residents. (#39 regarding feeding tube and urinary catheter, #32 and #9 regarding falls, #4 regarding the level of staff assistance required for (ADLs) Activities of Daily Living. Findings included: - Resident #39's admission (MDS) Minimum Data Set 3.0 assessment, dated 6/23/14, indicated the resident had short/long term memory problems, severely impaired decision making skills and acute mental changes. The MDS indicated the resident required total staff assistance for (ADLs) Activities of Daily Living, had no urinary catheter and no tube feeding, received a mechanically altered diet, and	F 280		

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received antibiotic medications 7 days of the look back period.

Review of the medical record revealed the facility re-admitted the resident from the hospital, on 7/16/14, with a feeding tube and urinary catheter in place.

The 7/16/14 care plan lacked interventions for the resident's feeding tube and urinary catheter.

The 7/16/14 physician's admission orders included Jevity (liquid nutritional supplement), 250 (cc) cubic centimeters, four times per day, via the resident's feeding tube. The physician's orders lacked any other instructions for the care of the feeding tube. The physician's orders included a urinary catheter due to difficulties with urinary obstruction.

On 7/17/14 at 9:40 AM, observation revealed the resident in bed with the head of the bed elevated approximately 30 degrees and a urinary catheter drainage bag attached to the bed frame. Further observation revealed Nurse L administered medication to the resident, through the resident's feeding tube. Nurse L provided a 30 cc water flush, 80 cc Arginaid (a supplement) mixed with a 12 gram protein drink, then flushed the feeding tube with 30 cc of water.

On 7/22/14 at 7:30 AM, Administrative Nurse A stated the admitting nurse should initiate the initial care plan interventions related to the current needs of the resident. He/she verified the staff had not updated the care plan with interventions or instructions for the resident's nutritional status, which included a feeding tube and nothing by mouth. Administrative Nurse A stated the facility did not have a care plan policy.

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The facility's 2/27/08 policy for abdominal tube feeding directed the nurses to confirm tube placement in the stomach and, after placement is confirmed, use a 60 cc syringe, allow 30 cc of water to flow into the tube to establish patency, and after the tube feeding, flush the tube with 30 cc of water.

The facility failed to revise the care plan for Resident #39, who was re-admitted to the facility with a urinary catheter, a feeding tube, and was not to receive anything by mouth, per the physician's orders.

- Resident #32's annual (MDS) Minimum Data Set 3.0 assessment, dated 2/5/14, indicated the resident had severely impaired cognition with a (BIMS) Brief interview for Mental Status score of 5. The MDS indicated the resident had moderately impaired vision, wore glasses and had wandering and verbal behaviors 1-3 days of the look back period. The resident was independent with (ADLs) Activities of Daily Living including walking and transfers, had no (ROM) Range of Motion impairment and used a walker. The resident's balance was unsteady with walking, he/she had 1 non-injury fall, received scheduled pain medications and antianxiety, antidepressive medications 7 days of the look back period.

The quarterly (MDS) Minimum Data Set 3.0 assessment, dated 4/23/14, indicated the same except a BIMS of 6, independent with bed mobility, transfers, walking, but required limited assistance with toileting. The resident's balance was unsteady but he/she was able to stabilize him/herself and had 1 non-injury fall.

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The 7/16/14 quarterly MDS indicated the same except BIMS 4, physical, verbal behaviors 1-3 days, rejected care and wandering 4-6 days. The MDS indicated the resident required extensive assistance with dressing, limited assistance with bed mobility, transfers, walking, toileting, had 2 or more non-injury falls, 2 or more minor injury falls since the prior MDS, and received antidepressive and diuretic medications 7 days.

The 2/6/14 (CAA) Care Area Assessment summary for falls indicated the resident had a history of falls prior to admission and had one fall this past quarter on 1-13-14. The CAA for ADLs indicated the resident required assistance with bathing but was otherwise fairly independent.

The 2/27/14 care plan for falls directed the staff to provide a walker, a night light in his/her room, remind the resident to get up slowly, analyze his/her falls for trends, ensure his/her eye glasses on and clean, ensure the resident wears proper footwear and the environment is free of clutter. Care plan updates included: 4/6/14 - assist the resident to toilet every 2 hours while awake. 4/10/14 -assist the resident to toilet at least once during the night shift. 4/30/14 - assist with transfers, ambulation. The 5/6/14 update of night light was already on the care plan. 5/8/14 - encourage the resident to nap in his/her room and not on the sofa. 5/25/14 - ensure call light within reach. The 6/2/14 update of cue the resident to stand slowly was already on the care plan. The 7/6/14 update to ensure the resident's room free of clutter was already on the care plan. 7/22/14 - try to get him/her to go to the dining room early. The 7/23/14 care plan for falls was the same.

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The 7/23/14 care plan conference summary indicated the resident's dementia was rapidly progressing and the resident's family was aware. The resident had a fall yesterday and now the staff tried to walk with him/her using a gait belt and a (FWW) front wheeled walker, but he/she became upset. The summary indicated the resident experienced multiple falls this past quarter and two of the falls resulted in head trauma. The resident resisted care at times, had a pressure pad alarm, but hated it, he/she hardly slept during the night, and needed extensive assistance with several ADLs.

The 2/3/14 Fall Risk score of 12 indicated the resident at high risk for falls. (10 or more indicated high risk). The 4/29/14 fall risk score of 18 and the 7/21/14 fall risk score of 20 indicated the resident's risk for falls was increasing.

The 4/6/14 at 5:35 PM, fall investigation indicated the staff found the resident on the floor in his/her room and the resident reported he/she accidentally urinated on the floor and slipped in the urine. The resident was able to report the events of the fall, denied pain and had no injury.

The 4/8/14 at 2:48 PM, fall investigation indicated the staff found the resident sitting on the floor in his/her room in front of the recliner. The resident could not recall how he/she got there and was naked except for a Wanderguard necklace. The floor was dry but the seat of the recliner was damp. The staff noted no injury, assisted the resident to dress and notified the physician and family. The note indicated the new fall intervention would be to check the resident frequently and offer assistance with toileting.

The 5/6/14 at 9:38 PM, fall investigation indicted

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the resident slept on the couch near the dining room and when the staff attempted to assist him/her to sit up, the resident slid, with staff assistance, to the floor without injury. Staff encouraged the resident to go to his/her room and rest in the recliner or bed when sleepy.

The 5/29/14 at 5:50 PM, fall investigation indicted the staff found the resident, in his/her room on the floor, without injury. The note indicated he/she was covered with a blanket and had a cushion under his/her head. The plan was to continue the current care plan.

The 6/23/14 at 12:21 PM, fall investigation summary indicated the staff found the resident sitting on floor next to the closet with his/her legs extended outward. The summary stated the resident was not wearing pants but had shoes and socks on and laughed and stated he/she was playing hide and seek. The staff noted 3 scratches to the resident's mid back which matched the top of the recliner. The note indicated the staff discussed decreasing furniture and objects in the resident's room, with the family, so he/she can get to things easier with his/her walker.

The facility's 7/6/14 investigation summary indicated at approximately 11:45 AM, Nurse Aid H found the resident on the floor with 2 pools of blood on the floor by the bed and blood covered the left side of his/her face. The resident had a 3 (cm) centimeter skin tear above his/her left eye and a 7 cm long laceration near the top of his/her head on the left side. The resident also had various small skin tears on his/her right hand. The resident stated he/she hit his/her head on the bedrail, but there was no blood on the bedrail. The resident had received Percocet (narcotic pain

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medication) at 9:40 AM for hip pain. The investigation stated staff transported the resident to the (ER) emergency room and the physician assessed a subcutaneous (under the skin) hematoma (pooled blood) at the laceration site. The investigation stated corrective actions included, after administering Percocet, check on the resident frequently and encourage the use of the call light for transfers.

The 7/6/14 ER report stated the resident, who remained conscious and answered questions appropriately, had a 7 cm laceration to the top of his/her head and a 2 cm forehead laceration with bleeding. The scalp laceration was stapled and palpation indicated a subcutaneous hematoma.

The 7/22/14 at 10:00 AM, nurse's note indicated the staff found the resident sitting on the floor in his/her bathroom in front of the toilet with a 3 cm skin tear to his/her mid forehead. The resident stated he/she hit his/her head on the floor and the skin tear was closed with glue and staff applied an ice pack. The note further indicated the resident did not like assistance and a personal alarm would be applied.

On 8/5/14 at 12:36 PM, observation revealed the resident got up from the table independently and a staff person went to him/her and assisted him/her with ambulation from the dining room to his/her room. Further observation revealed the resident had scabbed areas on his/her forehead and one pink colored mark/scar, approximately 3 cm long at the top of his/her forehead.

On 8/6/14 at 8:56 AM, observation revealed the resident independently ambulated with a walker from the dining room to the public restroom and then left his/her walker there. The resident had

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ambulated about 10 feet down the hall before he/she went back for it. He/She walked with a slight limp at a moderate pace. During the observation no staff were in the area.

On 8/7/14 at 1:45 PM, observation revealed the resident in the dining room independently moving dining chairs around. Further observation revealed his/her walker was near the table but he/she did not use it while moving chairs. During the observation no staff were in the area.

On 8/7/14 at 4:20 PM, Administrative Nurse A stated the resident was independent with ambulation in his/her room prior to his/her fall on 7/6/14. He/she stated the resident was still oriented enough to know what he/she was doing, but his/her safety inhibitions were declining. He/She stated the staff do not update the care plan with every fall and only update when a new fall intervention is needed. Administrative Nurse A verified the interventions for falls on 3 occasions were already on the care plan. He/she stated after a fall, the nurse's are to update the care plans and stated the nurses and nurse aides review the care plan in the computer.

The facility's 3/13/12 fall assessment policy and procedure directed the staff to complete the post fall event, determine potential cause of the fall and update the resident's care plan.

The facility failed to develop and implement effective interventions to prevent further falls for Resident #32, who experienced multiple falls in the past 4 months.

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F 280	Continued From page 10 - Resident #9's annual (MDS) Minimum Data Set 3.0 assessment, dated 2/26/14, indicated the resident understood/usually understands others, had adequate vision with glasses, and scored 11 on the (BIMS) Brief Interview for Mental Status, which indicated moderately impaired cognition. The MDS indicated the resident required limited assistance of 1 staff for dressing, toileting, grooming, the resident's balance was steady at all times during transitions/walking, and he/she had functional limitations in one upper extremity. The MDS indicated the resident ambulated with a walker and had one non-injury fall since the prior assessment. The 5/14/14 quarterly MDS was unchanged except the resident had functional limitations in both upper extremities and had no falls since the prior assessment. The 2/27/14 (CAAs) Care Area Assessment summary for falls indicated the resident was alert and oriented and verbally made his/her needs known. The CAAs indicated the resident was a high fall risk and had a history of falls. The 8/5/14 fall risk assessment revealed the resident scored 17, which was at risk. The 5/21/14 care plan instructed the staff to provide the resident with gripper socks and encourage him/her to wear them at night to help prevent slipping. The care plan instructed the staff to provide the resident with a walker for ambulation in his/her room or hall and provide an environment free of clutter. The 7/10/14 at 9:27 PM, nurse's notes indicated the staff found the resident on the bathroom floor, face down with a pool of smeared blood under	F 280		

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his/her head and a large contusion to the resident's right forehead with a large amount of blood noted. The nurse's note indicated the staff sent the resident to the emergency room for evaluation and the resident returned with new physician orders to continue current medications, Ultram (pain medication), three times a day, and as needed, hold Coumadin (blood thinner) for 2 days, do neurological checks per the facility protocol, not to cover the wound but dab as needed, to remove any drainage, and to hold the resident's Norco (narcotic pain medication), as resident received a Toradol (pain medication) injection in the emergency room.

The 7/10/14 post fall event indicated the resident stated he/she had slipped on something in the bathroom. The floor was noted to be dry with a box of wipes near the stool and the resident's slacks and brief, pulled down near his/her knees. The post fall event indicated the resident was alert and oriented, independent with his/her walker, and was wearing socks with skid grips.

On 8/6/14 at 7:25 AM, observation revealed the resident ambulated with his/her walker from his/her room to the dining room with a slow and steady gait. The resident had his/her glasses on and gripper socks.

On 8/5/14 at 2:15 PM, Nurse K verified the staff had not updated the resident's care plan since the 7/10/14 fall.

On 8/5/14 at 2:20 PM, Administrative Nurse A verified the staff had not reviewed and revised the resident's care plan after his/her the fall on 7/10/14.

The 3/1/12 facility fall assessment policy directed

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the staff to update the resident's care plan after a fall.

The facility failed to review and revised the care plan for Resident # 9 who had a fall and was sent to the emergency room for evaluation, to direct the staff to provide appropriate care to prevent further falls.

- Resident # 4's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 5/21/14, revealed a (BIMS) Brief Interview for Mental Status score of 2, which indicated severe cognitive impairment. The MDS indicated the resident required total staff assistance with his/her (ADLs) Activities of Daily Living, including eating, and had no swallowing problems.

The 12/18/13 nutrition (CAA) Care Area Assessment indicated the resident had nutrition problems, swallowing difficulties, a decline in ADLs and loss of arm movement.

The 5/28/14 care plan for nutrition/hydration instructed the staff to provide nectar thickened fluids and to thicken the liquids just prior to serving. The care plan stated the resident could hold a plastic sippy cup with 2 handles instead of a pitcher, and the staff were to ensure the pitcher was within his/her reach, with thickened Gatorade and a straw in it, when the resident was alone in his/her room. The staff were to provide adaptive devices as needed including a divided plate with a colored lip.

The 7/14/14 physician orders instructed the staff to provide nectar consistency fluids and finger foods with meals and snacks.

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F 280	Continued From page 13 On 8/5/14 at 12:55 PM observation revealed the staff provided total assistance to the resident who did not attempt to eat or drink independently. On 8/6/14 at 7:49 AM observation revealed the staff served the resident food on a regular plate. Further observation revealed the staff removed the plate of food and then served the resident's food on a yellow, undivided plate. On 8/6/14 at 12:53 PM, Nurse Aide A stated the resident was totally dependent on the staff for all cares and had not been able to feed him/herself for 2-3 months. On 8/7/14 at 4:58 PM Administrative Nurse F verified the staff provided total assistance to the resident with meals and fluids and no longer required a divided plate or sippy cups, however, the care plan did not reflect the resident's current needs. The facility failed to revise Resident #4's care plan to ensure the staff were knowledgeable regarding the level of assistance, and assistive devices, the resident required with eating/drinking.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on observation, record review and interview the facility failed to meet professional standards of quality care for 1 of 17 sampled residents by	F 281		

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leaving the resident's medications at his/her bedside, without watching the resident take their medications. (#7)

Findings included:

- Resident #7's quarterly (MDS) Minimum Data Set 3.0 assessment, indicated the resident scored 11 on the (BIMS) Brief Interview for Mental Status, which indicated severe cognitive impairment. The MDS indicated the resident had no behaviors and received 7 days of a diuretic medication.

The 3/8/14 (CAAs) Care Area Assessment summary, indicated the resident had mild cognitive impairment with confusion at times and no recent changes in anxiety psychoactive medications.

The 6/25/14 care plan instructed the staff to administer antianxiety medications, monitor the resident's behavior, and monitor Xanax (an antianxiety medication) for effectiveness and adverse consequences.

On 8/6/14 at 7:31 AM, during medication administration, observation revealed Nurse N left the following medications at the resident's bedside, then left the room without observing the resident take his/her medications:
Aspirin, (a pain, fever medication) 325 (mg) milligrams
Calcium 500 +D, (vitamin supplement)
Celebrex, (arthritis medication) 200 mg
Colace, (stool softener) 100 mg
Cozaar, (blood pressure medication) 100 mg
Imdur Extended Release, (angina medication) 60 mg
Lasix (diuretic medication), 20 mg

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F 281	Continued From page 15 Plavix, (antiplatelet medication) 85 mg Prilosec Delayed Release, (ulcer medication) 75 mg Senna, (laxative medication) 8.6 mg Xanax, (anxiety medication) 0.25 mg (½ tablet) On 8/6/14 at 7:31 AM, Nurse N stated the staff administered the resident's medication differently, than other residents, as the resident wanted his/her medications left on the bedside table in his/her room. Nurse N stated the resident would take his/her medication slowly, one or two pills at a time, and the resident had requested to self-administer his/her medications. Review of the resident's medical record revealed the staff had not completed a self-administration medication assessment, or a care plan indicating the resident could safely self-administer his/her medications. Further review of the record revealed no physician orders for self-administration of medication. On 8/7/14 at 2:05 PM, Nurse N verified the staff had not care planned self-administration of medications for the resident and did not know if the nurses would do a self-administration assessment on a resident. Nurse N stated the director of nursing would assess the resident upon admission to the facility, to determine if the resident would be capable of self-administration of his/her medications. On 8/7/14 at 4:58 PM, Administrative Nurse A verified a new resident would be assessed upon admission to determine if the resident was capable of doing self-administration of their medication. Administrative Nurse A verified the resident had not been assessed to self-administer his/her medications and the staff	F 281		

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F 281	Continued From page 16 had not placed it on the resident's care plan. Upon request, the facility did not provide a policy for a resident to self-administer his/her medication. The facility failed to assess Resident # 7 for safety of self-administration of his/her medications and failed to ensure appropriate administration of his/her medication.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on observation, interview and record review the facility failed to thoroughly assess the clinical status of 1 sampled resident. (#39) Findings included: - The 6/13/14 (POS) Physician Order Sheet for Resident #39 included diagnoses of gastric reflux (abnormal backward flow), depression, Benign Prostatic Hypertrophy (enlargement of the prostate gland near the urinary tract), chronic heart failure, hypertension (high blood pressure), chronic obstructive pulmonary disease (affects air exchange in the lungs), Parkinson's disease (a slow, progressive nerve disorder), and	F 309		

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F 309	Continued From page 17 pneumonia (infection of the lungs). The admission (MDS) Minimum Data Set 3.0 assessment, dated 6/23/14, indicated the resident had short/long term memory problems, severely impaired decision making skills and acute mental changes. The MDS indicated the resident required total staff assistance for (ADLs) Activities of Daily Living, his/her height was 75 inches and weight 178 (#) pounds. The MDS indicated the resident received a mechanically altered diet and antibiotic medication 7 days of the look back period. The 6/23/14 (CAA) Care Area Assessment for nutrition indicated the resident needed total staff assistance with eating and required honey thickened liquids. The resident currently had aspiration pneumonia (a lung infection potentially caused by inhaling solids into the lungs). The 6/13/14 initial care plan directed the staff to assess the resident for dehydration (change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucous membranes, sunken eyes, constipation, fever, infection and/or electrolyte imbalance), document the findings and notify the physician as needed. The care plan directed the staff to assist the resident with eating and hydration at every meal and offer thickened liquids during cares. The 6/14/14 care plan update for nutrition directed the staff to provide honey thickened liquids, assist the resident with eating and watch him/her for choking and swallowing problems. The care plan instructed the staff to ensure the resident sat upright before and after eating/drinking and to keep the resident's (HOB) head of the bed elevated.	F 309		

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The 6/13/14 admission nursing assessment indicated the resident had a pink, moist tongue, clear lung sounds, no cough, no sputum, no swelling and no feeding tube. The assessment indicated the resident received a pureed diet with thickened liquids and staff were to straight cath (intermittently empty the bladder using a catheter tube) the resident, daily for 10 days.

The 6/13/14 physician's order directed the staff to administer Cipro (antibiotic), 500 (mg) milligrams, by mouth, twice daily for 6 days for a diagnosis of pneumonia. The order also directed staff to provide the resident a regular pureed diet.

Review of the medical record revealed no dietary assessment for the resident, from 6/13/14 to 6/24/14, at which time the resident returned to the hospital with diagnoses of dehydration and pneumonia.

The 6/13/14 at 11:00 AM, nurse's note indicated the resident's lung sounds were clear, his/her skin was warm, pink and dry and the resident's vital signs (temperature, pulse, blood pressure, respirations) all within normal range.

The nurse's notes from 6/14 to 6/19/14 indicated the resident ate and drank fluids slowly, choked easily, and his/her urine was amber to dark tea colored and had a foul odor. The notes indicated the resident continued on antibiotics for a diagnosis of pneumonia.

The 6/19/14 physician's order included a speech consultation and honey thickened liquids.

The 6/21/14 at 3:45 PM, nurse's note indicated the resident had a "raspy" cough, no choking this shift, the resident had taken a small amount of

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thickened liquids today and the resident's urine was reddish tinged, amber colored with a fair amount of mucous. The note indicated the nurse contacted the physician regarding another matter for the resident, but included no documentation the nurse informed the physician of the resident's "raspy" cough and poor intake.

The 6/22/14 at 4:20 PM, nurse's note indicated the resident's lung sounds were coarse (not clear), his/her skin was clammy/warm, and he/she had a temperature of 97 degrees. The note indicated the resident's family member requested the staff notify the physician.

Further review of the medical record revealed no additional documentation, from 6/14- 6/22/14, that the nurses assessed the resident's lung sounds.

The 6/23/14 physician's order directed the staff to obtain a chest x-ray, (CBC) complete blood count and (CMP) complete metabolic profile blood laboratory work for the resident.

The 6/23/14 physician's order directed the staff to provide a high protein pureed diet with thickened liquids for the resident.

Further nurse's notes indicated the following:

6/23/14 at 3:53 PM, the resident choked on a large amount of phlegm (sticky mucous), nursing staff suctioned him/her and notified the physician.

6/24/14 at 1:15 AM, nursing staff applied oxygen per nasal cannula at 2 liters per minute and administered a respiratory treatment to the resident. The note indicated the nurse crushed and administered medications with thickened liquids. The note further indicated the resident

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was unable to clear his/her throat of phlegm and the staff suctioned him/her. The note lacked indication the nurse assessed the resident's lung sounds.

6/24/14 at 5:34 PM, the resident was unable to swallow medications this morning, was lethargic (abnormal lack of energy) and hard to arouse. The note indicated staff notified the physician and made an appointment for the resident. The note further indicated the resident rested in bed, moaned, and appeared uncomfortable at times. The note stated the staff did not provide the resident fluids due to the resident being unable to swallow and the note lacked indication the nurse assessed the resident's lung sounds during the day. The note further indicated the physician admitted the resident to the hospital directly from the physician's appointment with diagnoses of dehydration and pneumonia.

The 6/24/14 hospital admission history and physical stated the resident came to the office today because the facility nurses were concerned that he/she was not swallowing and did not have anything to eat or drink today. The document stated the physician was concerned about dehydration, infection and the chest x-ray showed infiltrate (material) in the resident's left lower lobe of the lungs. The document stated the resident had a cough, choked on food and the nurses suctioned him/her several times. The document stated the resident's oxygen saturation was 88% (normal range was 90-100%) on room air, his/her skin color was dusky (darker than normal), mucous membranes were extremely dry and he/she had food and debris caked onto the soft palate (separates the roof of the mouth from the back of the mouth). The physician's assessment included the following: (1) dehydration (2)

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pneumonia, (3) Parkinson's disease exacerbated (irritated), (4) dementia, (5) obstructive uropathy (a condition that blocks the flow of urine), (6) hypernatremia (a greater than normal concentration of sodium in the blood) with sodium of 150. The document stated the plan was to admit the resident to the hospital, start fluids and administer antibiotics. The document stated the physician cautioned the resident's family member about the resident's serious condition.

The 6/27/14 hospital admission to swing bed history and physical stated the hospital admitted the resident with severe dehydration and bilateral pneumonia. The document indicated the resident's sodium level came down, the resident has been hydrated and his/her cognitive status improved.

On 7/17/14 at 9:40 AM, observation revealed the resident in bed with the HOB elevated approximately 30 degrees. Further observation revealed Nurse A administered medication through the resident's feeding tube.

On 7/21/14 at 2:10 PM, Nurse G stated he/she had called the physician on 6/24/14 in the morning, regarding the resident's choking on phlegm and no food/fluid intake and the resident went to the physician appointment in midafternoon. He/she stated staff did not monitor the resident's total intake of fluids, including fluids provided during care and normally do not document intake. He/she stated the staff monitored for signs and symptoms of dehydration and offered fluids with all cares and meals.

On 7/22/14 at 5:45 PM, Physician H stated the resident had a lot of comorbidities (coexisting diseases) and he/she was unsure if the second

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F 309	Continued From page 22 admission to the hospital (6/24/14) was a re-occurrence of pneumonia or aspiration and the resident had difficulty clearing secretions due to his/her Parkinson's disease. Physician H stated the resident was alert within 12 hours of re-admission to the hospital on 6/24/14 and verified the physician on call had re-admitted the resident to the hospital with dehydration and pneumonia, but the dehydration was because of the pneumonia. On 7/23/14 at 4:30 PM, Nurse C verified the facility had no further documentation of lungs sounds for Resident #39. The facility's undated Physician Notification policy and procedure stated the nurse must make the appropriate assessments of the resident's condition prior to contacting the physician and must document the assessment. The facility failed to thoroughly assess the respiratory condition of Resident #39, who the facility identified as being at high risk for dehydration, aspiration and pneumonia when he/she developed signs and symptoms of possible respiration problems, including coarse lung sounds, raspy cough and poor intake which required re-admission to the hospital with a diagnosis of pneumonia.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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This Requirement is not met as evidenced by:
The facility had a census of 34 residents. The sample included 7 residents with 3 reviewed for (ADL's) Activities of Daily Living. Based on observation, interview, and record review the facility failed to provide assistance for ADL's and correctly thickened fluids for 1 of 3 sampled residents. (# 4)

Findings Included:

- Resident # 4's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 5/21/14, revealed a (BIMS) Brief Interview for Mental Status score of 2, which indicated severe cognitive impairment. The resident required total assistance with his/her ADL's and unable to balance him/herself to maintain upper torso balance.

The 10/23/14 ADL function (CAA) Care Area Assessment revealed the resident had been hospitalized recently with a decline in mental status, and required extensive to total assistance for the majority of his/her ADL's.

The 3/5/14 care plan for ADL function instructed staff to provide 2 person assistance and reposition the resident every 2 hours.

The 7/14/14 physician orders instructed staff to elevate the resident legs, allow up in the wheelchair as tolerated, and provide a total lift for all transfers.

On 8/5/14 12:55 PM, observation revealed the resident leaned to the right in the wheelchair, his/her torso slouched down in the chair.

On 8/6/14 at 7:49 AM, observation revealed the

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F 312	Continued From page 24 resident at the dining room table with his/her feet slightly elevated in the wheelchair, legs dangling over the footboard, and not touching the base. On 8/6/14 at 4:04 PM, Nurse Aide P stated the resident was very stiff and difficult to work with, and added he/she could not stay upright in the wheelchair. On 8/12/14 at 2:30 PM, Nurse A verified the resident did not maintain appropriate body positioning and leaned into the wheelchair side. The facility failed to provide equipment and /or devices to maintain Resident #4's proper body alignment when seated in his/her wheelchair.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents of which 3 were reviewed for pressure ulcers. Based on observation, interview and record review the facility failed to provide necessary treatment and services to prevent the development of pressure ulcers for 1 of 3 residents sampled for pressure ulcers. (#39)	F 314		

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F 314	Continued From page 25 Findings included: - Resident #39's admission (MDS) Minimum Data Set 3.0 assessment, dated 6/23/14, indicated the resident had short/long term memory problems, severely impaired decision making skills, and acute mental status changes. The MDS indicated the resident required total staff assistance for (ADLs) Activities of Daily Living, including bed mobility and transfers, had no (ROM) Range of Motion limitations, his/her height was 75 inches and weight 178 (#) pounds. The MDS indicated the resident received a mechanically altered diet and antibiotic medication for 7 days of the look back period. The MDS indicated the resident had a Stage 1, unhealed pressure ulcer, with granulation (soft pink projection of tissues that form during wound healing) and skin breakdown interventions which included pressure relief for the bed and chair, repositioning, nutrition, and ulcer care. The 6/23/14 (CAA) Care Area Assessment summary for pressure ulcers indicated the resident was non-ambulatory, required the assistance of two staff and a full lift for all transfers. The summary stated the resident required total staff assistance with bed mobility and developed an open area on day 5 of his/her admission to the facility. The summary indicated the resident had a Stage 1 pressure ulcer (previously documented as a Stage 2, open area) or abraised (scraped) area on his/her right buttocks, received treatment, and showed healing with granulation tissue present. The 6/13/14 initial care plan lacked interventions to prevent skin breakdown. The 6/18/14 care plan	F 314		

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update indicated the resident at risk for skin breakdown, needed assistance with bed mobility, and had a Stage 2 ulcer to his/her right buttock. The 6/19/14 care plan update directed the staff to assist the resident with repositioning every 2 hours and keep pressure off his/her right buttock.

The 6/13/14 admission skin assessment indicated the resident had no open areas or blisters.

The 6/14/14 Braden scale (a scale used to assess the potential for skin breakdown) indicated the resident was at high risk for skin breakdown with a score of 12 (10-12 indicated high risk), he/she had very limited mobility, and probable inadequate nutrition intake. The assessment indicated the resident frequently had moist skin and the linens must be changed every shift.

The 6/18/14 at 5:57 PM, nurse's note indicated the resident had an open area, approximately 0.5 (cm) centimeters in diameter on his/her right buttock. The note further indicated the open area was a Stage 2 pressure ulcer with pink intact skin surrounding it, without drainage or odor. The staff notified the physician and applied an Alevyn (wound bandage) dressing per physician's order.

The 6/18/14 physician's order directed the staff to apply an Alevyn dressing to the open area on the resident's right buttock until healed and obtain a Dietary Consult for an evaluation of the resident's nutritional status due to the development of a pressure sore. The physician's wound care orders did not indicate how often the staff were to change the dressing.

Review of the medical record revealed no dietary

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consultant assessment for the resident from the time of admission on 6/13/14 to 6/24/14.

The 6/19/14 Braden Scale score was 11 and the assessment indicated the resident had very poor nutrition and interventions to prevent skin breakdown included pressure relieving devices to the resident's chair and bed, repositioning, nutrition, pressure ulcer care, and application of dressings/medications.

Review of the nurse's notes revealed the following:
6/19/14 at 3:10 AM- open area to right buttock, dressing dry and intact.
6/19/14 at 1:10 PM- provided dietary manager information to fax to the dietician regarding the resident's ulcer.
6/19/14 at 3:12 PM- Alevyn dressing to the right buttock was clean, dry and intact.
6/20/14 at 3:45 PM- coccyx dark red with shearing, groin is red, and the staff applied barrier cream.
6/21/14 at 3:46 AM- redness noted on coccyx.
6/21/14 at 3:45 PM- Alevyn dressing applied to open area on the right buttock. The area is pink and starting to granulate in.
6/22/14 at 4:16 PM- pressure sore to right buttock is now a Stage 1, 0.5 cm diameter with pink granulation tissue in the center with no drainage, no odor.
6/23/14 at 4:12 PM- groin continues to be red and buttock is dark red with shearing, staff repositioned the resident on air mattress.
7/16/14 at 6:24 PM- Alevyn dressing on his/her coccyx removed and not replaced because skin is intact in this area, although there is red scar-like tissue surrounding coccyx.

On 7/17/14 at 9:40 AM, observation revealed the

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resident in bed with the HOB elevated approximately 30 degrees. Further observation revealed Nurse A administered medication through the resident's feeding tube.

On 7/21/14 at 9:57 AM, observation revealed Nurse Aide Q provided repositioning and incontinence care. Further observation revealed no open skin on the resident's buttocks.

On 7/21/14 at 11:45 AM, Dietary Manager E verified neither the (RD) Registered Dietician nor he/she had completed a nutritional assessment of the resident, including his/her estimated fluid needs, for the initial 6/13/14 admission to the facility. He/she was unaware of the physician order for a dietary consult.

On 8/7/14 at 2:55 PM, Nurse N stated the staff used the Braden scale to assess the potential for skin breakdown and then further evaluate what needs to be initiated to prevent skin breakdown. He/she stated the resident was still standing with assistance when he/she was admitted on 6/13/14 and the staff provided assistance with repositioning. Nurse N stated the staff are to notify the dietary manager if the Braden scale indicated a need for nutritional evaluation or intervention.

On 8/7/14 at 3:55 PM, Administrative Nurse A verified the resident had developed the pressure ulcer 5 days after admission to the facility. He/she stated the resident's Braden scale indicated the resident was at high risk and the staff initiated a repositioning program and provided a gel pad in his/her chair. Administrative Nurse A stated the staff are to notify the RD of new admissions. He/She stated all the facility's mattresses are a specialty mattress and they don't use an air

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F 314	Continued From page 29 mattress until actual skin breakdown occurred. The facility's 11/8/13 Wound Care policy stated preventive skin care measures are to be used for all residents. At admission all residents are assessed by a nurse for potential skin risk, necessary interventions would be implemented and care planned. The policy stated all beds in the facility have a pressure relieving mattress. Residents identified as "at risk" would be assessed by the care plan team and the appropriate cushions placed in wheelchairs and chairs. Repositioning schedules will be implemented as indicated and the staff are instructed to reposition residents who are unable to reposition themselves every 2 hours. Assessment for residents with wounds will include a physician assessment and a nutritional assessment for residents with ulcers. The policy directed the staff to review the care plan and check to see if additional interventions are needed, add interventions to the care plan, notify the dietary manager, if applicable, so dietary interventions can be started and notify the physician of any Stage 1, 2 or 3 pressure ulcer. The facility failed to provide treatment and services for Resident #39 to prevent a facility acquired, Stage 2 pressure ulcer 5 days after his/her admission to the facility.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric	F 322		

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F 322	Continued From page 30 tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on observation, interview and record review the facility failed to provide the specified amount of water flushes between each medication administered to 1 sampled resident with a feeding tube. (#39) Findings included: - Resident #39's admission (MDS) Minimum Data Set 3.0 assessment, dated 6/23/14, indicated the resident had short/long term memory problems, severely impaired decision making skill and acute mental changes. The MDS indicated the resident required total staff assistance for (ADLs) Activities of Daily Living, had no tube feeding, received a mechanically altered diet, and received antibiotic medications 7 days of the look back period and (IV) intravenous medications.	F 322		

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The 6/23/14 (CAA) Care Area Assessment summary for nutrition indicated the resident needed to be spoon fed by the staff and required honey thickened liquids. The summary indicated he/she currently has aspiration pneumonia (a lung infection potentially caused by inhaling solids into the lungs). The CAA summary for hydration indicated the resident required honey thickened liquids, required total staff assistance with eating and he/she was unable to drink independently. The CAA summary further indicated the resident was at high risk for dehydration and had aspiration pneumonia. The summary stated the resident experienced a sudden acute illness on top of his/her dementia, Parkinson's disease, and he/she had a significant deterioration in his/her health status.

The 7/16/14 care plan lacked indications the resident had a feeding tube.

The 7/16/14 physician's admission orders included Jevity (liquid nutritional supplement), 250 (cc) cubic centimeters, four times per day, via the resident's feeding tube.

On 7/17/14 at 9:40 AM, observation revealed the resident in bed with the head of the bed elevated approximately 30 degrees. Further observation revealed Nurse L administered, to the resident, medication through the resident's feeding tube. Nurse L provided a 30 cc water flush, 80 cc Arginaid (a supplement) mixed with a 12 gram protein drink, then flushed the feeding tube with 30 cc of water.

On 7/22/14 at 8:22 AM, observation revealed Nurse J prepared and administered, to the resident, the following medications through the

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F 322	Continued From page 32 feeding tube: Potassium (a necessary chemical component of diet) liquid, 15 (ml) milliliters, Lexapro (antidepressive), 10 (mg) milligrams, crushed. Protonix (gastric acid inhibitor), 40 mg, crushed. Parolodel (anti Parkinson medication), 2.5 mg, ½ tablet, crushed. Mirapex (anti Parkinson medication), 1 mg, crushed. Sinemet ((anti Parkinson medication), 25/250 mg, crushed. Macrobid (antibiotic), 100 mg, capsule, opened and mixed with other medications. Folic acid (vitamin), 800 mg, crushed. Aspirin (anti-inflammatory drug), 81 mg. Protein shot, 12 gram per 2.5 (oz.) ounce liquid. Arginaid, liquid 8 oz. Continued observation revealed Nurse J mixed the crushed pills in 30 cc water and mixed them into the liquid potassium. Observation revealed Nurse J used a 60cc syringe and a stethoscope to check the feeding tube placement, then he/she flushed the feeding tube with 30 cc water. Nurse J administered ½ of a can of Jevity 1.5 per gravity drip, then the crushed, mixed medications with the protein shot and the Arginaid through the feeding tube. Nurse J administered the other ½ of the can of Jevity, and then flushed with 30 cc water. Nurse J verified he/she did not flush with water before or after administering the medications and stated he/she normally did not provide a water flush before or after medications during the tube feedings. On 7/22/14 at 10:30 AM, Administrative Nurse A verified the staff are to flush the feeding tube with 30 cc of water before and after medication administration and flush with 15 cc of water between each medication.	F 322		

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F 322	Continued From page 33 The facility's 2/27/08 abdominal tube feeding policy directed the staff to confirm tube placement in the stomach, use a 60 cc syringe and allow 30 cc water to flow into the tube to establish patency, and after the feeding, flush the tube with 30 cc water. The policy further stated the staff are to flush the feeding tube with 30 cc of water before and after medication administration and flush with 15 cc of water between each medication. The facility failed to use the appropriate water flushes prior to administration of medication and between each medication administered through the feeding tube, per the facility's policy, for Resident #39.	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on observation, interview and record review the facility failed to provide adequate supervision and intervention to prevent further falls for 1 of 5 residents reviewed for accidents (#32) and failed to provide an environment free of accident hazards for 11 cognitively impaired, independently mobile residents, as identified by the staff, who resided in the facility.	F 323		

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F 323	Continued From page 34 Findings included: - Resident #32's annual (MDS) Minimum Data Set 3.0 assessment, dated 2/5/14, indicated the resident had severely impaired cognition with a (BIMS) Brief interview for Mental Status score of 5. The MDS indicated the resident had moderately impaired vision, wore glasses and had wandering and verbal behaviors 1-3 days of the look back period. The resident was independent with (ADLs) Activities of Daily Living including walking and transfers, had no (ROM) Range of Motion impairment and used a walker. The resident's balance was unsteady with walking, he/she had 1 non-injury fall, received scheduled pain medications and antianxiety, antidepressive medications 7 days of the look back period. The quarterly (MDS) Minimum Data Set 3.0 assessment, dated 4/23/14, indicated the same except a BIMS of 6, independent with bed mobility, transfers, walking, but required limited assistance with toileting. The resident's balance was unsteady but he/she was able to stabilize him/herself and had 1 non-injury fall. The 7/16/14 quarterly MDS indicated the same except BIMS 4, physical, verbal behaviors 1-3 days, rejected care and wandering 4-6 days. The MDS indicated the resident required extensive assistance with dressing, limited assistance with bed mobility, transfers, walking, toileting, had 2 or more non-injury falls, 2 or more minor injury falls since the prior MDS, and received antidepressive and diuretic medications 7 days. The 2/6/14 (CAA) Care Area Assessment summary for falls indicated the resident had a history of falls prior to admission and had one fall	F 323		

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this past quarter on 1-13-14. The CAA for ADLs indicated the resident required assistance with bathing but was otherwise fairly independent.

The 2/27/14 care plan for falls directed the staff to provide a walker, a night light in his/her room, remind the resident to get up slowly, analyze his/her falls for trends, ensure his/her eye glasses on and clean, ensure the resident wears proper footwear and the environment is free of clutter.

Care plan updates included: 4/6/14 - assist the resident to toilet every 2 hours while awake. 4/10/14 -assist the resident to toilet at least once during the night shift. 4/30/14 - assist with transfers, ambulation. The 5/6/14 update of night light was already on the care plan. 5/8/14 - encourage the resident to nap in his/her room and not on the sofa. 5/25/14 - ensure call light within reach. The 6/2/14 update of cue the resident to stand slowly was already on the care plan. The 7/6/14 update to ensure the resident's room free of clutter was already on the care plan. 7/22/14 - try to get him/her to go to the dining room early. The 7/23/14 care plan for falls was the same.

The 7/23/14 care plan conference summary indicated the resident's dementia was rapidly progressing and the resident's family was aware. The resident had a fall yesterday and now the staff is trying to walk with him/her using a gait belt and a (FWW) front wheeled walker, but he/she became upset. The summary indicated the resident experienced multiple falls this past quarter and two of the falls resulted in head trauma. The resident resisted care at times, had a pressure pad alarm, but hated it, he/she hardly slept during the night, and needed extensive assistance with several ADLs.

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F 323	Continued From page 36 The 2/3/14 Fall Risk score of 12 indicated the resident at high risk for falls. (10 or more indicated high risk). The 4/29/14 fall risk score of 18 and the 7/21/14 fall risk score of 20 indicated the resident ' s risk for falls was increasing. The 4/6/14 at 5:35 PM, fall investigation indicated the staff found the resident on the floor in his/her room and the resident reported he/she accidently urinated on the floor and slipped in the urine. The resident was able to report the events of the fall, denied pain and had no injury. The 4/8/14 at 2:48 PM, fall investigation indicated the staff found the resident sitting on the floor in his/her room in front of the recliner. The resident could not recall how he/she got there and was naked except for a Wanderguard necklace. The floor was dry but the seat of the recliner was damp. The staff noted no injury, assisted the resident to dress and notified the physician and family. The note indicated the new fall intervention would be to check the resident frequently and offer assistance with toileting. The 5/6/14 at 9:38 PM, fall investigation indicted the resident slept on the couch near the dining room and when the staff attempted to assist him/her to sit up, the resident slid, with staff assistance, to the floor without injury. Staff encouraged the resident to go to his/her room and rest in the recliner or bed when sleepy. The 5/29/14 at 5:50 PM, fall investigation indicted the staff found the resident, in his/her room on the floor, without injury. The note indicated he/she was covered with a blanket and had a cushion under his/her head. The plan was to continue the current care plan.	F 323		

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The 6/23/14 at 12:21 PM, fall investigation summary indicated the staff found the resident sitting on floor next to the closet with his/her legs extended outward. The summary stated the resident was not wearing pants but had shoes and socks on and laughed and stated he/she was playing hide and seek. The staff noted 3 scratches to the resident ' s mid back which matched the top of the recliner. The note indicated the staff discussed decreasing furniture and objects in the resident's room, with family, so he/she can get to things easier with his/her walker.

The facility's 7/6/14 investigation summary indicated at approximately 11:45 AM, Nurse Aid H found the resident on the floor with 2 pools of blood on the floor by the bed and blood covered the left side of his/her face. The resident had a 3 (cm) centimeter skin tear above his/her left eye and a 7 cm long laceration near the top of his/her head on the left side. The resident also had various small skin tears on his/her right hand. The resident stated he/she hit his/her head on the bedrail, but there was no blood on the bedrail. The resident had received Percocet (narcotic pain medication) at 9:40 AM for hip pain. The investigation stated staff transported the resident to the (ER) emergency room and the physician assessed a subcutaneous (under the skin) hematoma (pooled blood) at the laceration site. The investigation stated corrective actions included, after administering Percocet, check on the resident frequently and encourage the use of the call light for transfers.

The 7/6/14 ER report stated the resident, who remained conscious and answered questions appropriately, had a 7 cm laceration to the top of

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his/her head and a 2 cm forehead laceration with bleeding. The scalp laceration was stapled and palpation indicated a subcutaneous hematoma.

The 7/22/14 at 10:00 AM, nurse ' s note indicated the staff found the resident sitting on the floor in his/her bathroom in front of the toilet with a 3 cm skin tear to his/her mid forehead. The resident stated he/she hit his/her head on the floor and the skin tear was closed with glue and staff applied an ice pack. The note further indicated the resident did not like assistance and a personal alarm would be applied.

On 8/5/14 at 12:36 PM, observation revealed the resident got up from the table independently and a staff person went to him/her and assisted him/her with ambulation from the dining room to his/her room. Further observation revealed the resident had scabbed areas on his/her forehead and one pink colored mark/scar, approximately 3 cm long at the top of his/her forehead.

On 8/6/14 at 8:56 AM, observation revealed the resident independently ambulated with a walker from the dining room to the public restroom and then left his/her walker there. The resident had ambulated about 10 feet down the hall before he/she went back for it. He/She walked with a slight limp at a moderate pace. During the observation no staff were in the area.

On 8/7/14 at 1:45 PM, observation revealed the resident in the dining room independently moving dining chairs around. Further observation revealed his/her walker was near the table but he/she did not use it while moving chairs. During the observation no staff were in the area.

On 8/7/14 at 4:20 PM, Administrative Nurse A

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F 323	Continued From page 39 stated the resident was independent with ambulation in his/her room prior to his/her fall on 7/6/14. He/she stated the resident was still oriented enough to know what he/she was doing, but his/her safety inhibitions were declining. He/She stated the staff do not update the care plan with every fall and only update when a new fall intervention is needed. Administrative Nurse A verified the interventions for falls on 3 occasions were already on the care plan. He/she stated after a fall, the nurse's are to update the care plans and stated the nurses and nurse aides review the care plan in the computer. The facility's 3/13/12 fall assessment policy and procedure directed the staff to complete the post fall event, determine potential cause of the fall and update the resident's care plan. The facility failed to develop and implement effective interventions to prevent further falls for Resident #32, who experienced multiple falls in the past 4 months. - On 8/4/14 at 9:15 AM, during the initial facility tour, observation in the activity room revealed the following hazardous chemicals in an unlocked cabinet under the activity room sink: (1) Dawn power dissolvent, 1 quart plastic bottle with a label warning of skin and eye irritant. (2) A 1 quart spray bottle of 409 cleaner and a 1 quart spray bottle of Silks Alive (artificial plant cleaner) with a Keep out of Reach of Children warning on the label. (3) One 8 ounce bottle of Novus 2 fine scratch remover with a label warning to avoid contact to	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 40 eyes. Activity Staff H verified the chemical hazards were accessible at the time of the observation. On 8/4/14 at 9:27 AM, observation revealed, in the unlocked cabinet under the dining room sink, a 1 quart spray bottle of Total solution (disinfectant) with the warning label of hazardous to humans, animals, moderate eye irritation and keep out of reach of children and a 1 quart bottle of foaming hand wash with a keep out of reach of children label. Consultant Staff B verified the observation and stated the chemicals should not have been stored in the unlocked cabinet. The facility's undated Hazardous Chemical Storage policy stated all staff are to be involved in observing and identifying potential hazards in the environment and removing them for proper storage. Any item that has the warning of keep out of reach of children or eye irritant should be removed from the residents' environment. The facility failed to provide an environment free of potential accident hazards for the facility's 11 cognitively impaired, independently mobile residents, as identified by the staff, who reside in the facility.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	F 325		

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	17E183	A. BUILDING _____ B. WING _____	08/19/2014

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F 325	Continued From page 41 demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on observation, interview and record review the facility failed to provide a nutritional assessment to establish dietary needs and interventions for 1 of 5 residents reviewed for nutrition. (#39) Findings included: - The 6/13/14 (POS) Physician Order Sheet for Resident #39 included diagnoses of gastric reflux (abnormal backward flow), depression, Benign Prostatic Hypertrophy (enlargement of the prostate gland near the urinary tract), chronic heart failure, hypertension (high blood pressure), chronic obstructive pulmonary disease (affects air exchange in the lungs), Parkinson's disease (a slowly progressive nerve disorder), and pneumonia (infection of the lungs). Resident #39's admission (MDS) Minimum Data Set 3.0 assessment, dated 6/23/14, indicated the resident had short/long term memory problems, severely impaired decision making skills and acute mental changes. The MDS indicated the resident required total staff assistance for (ADLs) Activities of Daily Living, his/her height was 75 inches, and weight of 178 (#) pounds. The MDS indicated the resident received a mechanically altered diet, and had no swallowing or dental issues.	F 325		

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The 6/23/14 (CAA) Care Area Assessment for nutrition indicated the resident required total staff assistance with eating and required honey thickened liquids. The resident currently had aspiration pneumonia (a lung infection potentially caused by inhaling solids into the lungs).

The CAA for hydration indicated the resident required honey thickened liquids, and he/she was unable to drink independently. The CAA further indicated the resident was at high risk for dehydration and he/she had aspiration pneumonia. The resident experienced a sudden acute illness on top of his/her dementia and severe Parkinson's disease and he/she had a significant deterioration in his/her health status.

The 6/13/14 initial care plan directed the staff to assess the resident for dehydration (change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucous membranes, sunken eyes, constipation, fever, infection and/or electrolyte imbalance), document the findings and notify the physician as needed. The care plan directed the staff to assist the resident with eating and drinking at every meal and offer thickened liquids during cares. The 6/14/14 care plan update for nutrition directed the staff to provide honey thickened liquids, assist the resident with eating and watch him/her for choking and swallowing problems. The care plan instructed the staff to ensure the resident sat upright before and after eating/drinking and to keep the resident's head of the bed elevated.

The 6/13/14 physician's order directed the staff to provide the resident a regular pureed diet.

The 6/14/14 at 5:25 PM, nurse's notes indicated

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the resident ate and drank fluids slowly, and choked easily.

The 6/19/14 physician's order included a speech consultation and honey thickened liquids..

Review of the medical record revealed no dietary assessment for the resident, from 6/13/14 to 6/24/14, at which time the resident returned to the hospital with diagnoses of dehydration and pneumonia.

The 6/23/14 physician's order directed the staff to provide a high protein pureed diet with thickened liquids for the resident.

The 6/24/14 at 5:34 PM, nurse's note indicated the resident was unable to swallow medications this morning, was lethargic (abnormal lack of energy) and hard to arouse. The note indicated staff notified the physician and made an appointment for the resident. The note further indicated the resident rested in bed, moaned, and appeared uncomfortable at times. The note stated the staff did not provide the resident fluids due to the resident being unable to swallow. The note further indicated the physician admitted the resident to the hospital directly from the physician's appointment with diagnoses of dehydration and pneumonia.

The medical record revealed the resident weighed 176.8 # (80.36 kilograms) on 6/11/14, just prior to admission to the nursing facility. The staff did not obtain an admission weight on the resident when admitting him/her to the nursing facility.

The 6/24/14 hospital admission history and physical stated the resident came to the office

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today because the facility nurses were concerned that he/she was not swallowing and did not have anything to eat or drink today. The document stated the physician was concerned about dehydration, infection and the chest x-ray showed infiltrate (material) in the resident's left lower lobe of the lungs. The document stated the resident had a cough, choked on food and the nurses suctioned him/her several times. The document stated the resident's oxygen saturation was 88% (normal range was 90-100%) on room air, his/her skin color was dusky (darker than normal), mucous membranes were extremely dry and he/she had food and debris caked onto the soft palate (separates the roof of the mouth from the back of the mouth). The physician's assessment included the following: (1) dehydration (2) pneumonia, (3) Parkinson's disease exacerbated (irritated), (4) dementia, (5) obstructive uropathy (a condition that blocks the flow of urine), (6) hypernatremia (a greater than normal concentration of sodium in the blood) with sodium of 150. The document stated the plan was to admit the resident to the hospital, start fluids and administer antibiotics. The document stated the physician cautioned the resident's family member about the resident's grave (serious) condition.

Review of the medical record revealed the resident returned to the nursing facility on 7/16/14.

On 7/17/14 at 9:40 AM, observation revealed the resident in bed with the head of the bed elevated approximately 30 degrees. Further observation revealed Nurse L administered medication through the resident's gastric tube. Nurse L provided a 30 cc water flush, 8 oz. of Arginaid (a supplement) mixed with a 12 gram protein drink, then flushed the gastric tube with 30 cc of water.

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F 325	Continued From page 45 On 7/21/14 at 11:45 AM, Dietary Manager C verified neither the (RD) Registered Dietician nor he/she had completed a nutritional assessment of the resident, including his/her estimated fluid needs, for the initial 6/13/14 admission to the facility. On 7/21/14 at 2:10 PM, Nurse N stated he/she had called the physician on 6/24/14 in the morning, regarding the resident's choking on phlegm and no food/fluid intake and the resident went to the physician appointment in midafternoon. He/she stated staff did not monitor the resident's total intake of fluids, including fluids provided during care, during June and normally do not document intake. He/she stated the staff monitored for signs and symptoms of dehydration and offered fluids with all cares and meals. On 7/22/14 at 7:30 AM, Administrative Nurse A stated the admitting nurse should initiate the initial care plan interventions related to the current needs of the resident. He/She verified the staff had not updated the care plan when the facility re-admitted the resident with interventions or instructions for the resident's nutritional status, which would indicate he/she was to receive nothing by mouth, had a feeding tube and received tube feedings. Administrative Nurse A stated the facility did not have a nutrition policy. The facility failed to provide nutritional/hydration assessments for Resident #39, who was admitted to the facility on a mechanically altered diet, required total staff assistance with eating, and was then re-admitted to the hospital with diagnoses of dehydration and hypernatremia. The facility failed to ensure a thorough nutritional assessment when the resident was re-admitted, a	F 325		

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F 325	Continued From page 46 second time, to the facility with a feeding tube through which he/she received his/her total nutrition.	F 325		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on observation, interview and record review the facility failed to provide and monitor sufficient fluid intake to maintain proper hydration and health for 2 of 3 residents sampled for hydration. (#39, who was admitted to the hospital with diagnoses of severe dehydration and hypernatremia (a greater than normal concentration of sodium in the blood) and #4 regarding fluid consistently.) Findings included: - The 6/13/14 (POS) Physician Order Sheet for Resident #39 included diagnoses of gastric reflux (abnormal backward flow), depression, Benign Prostatic Hypertrophy (enlargement of the prostate gland near the urinary tract), chronic heart failure, hypertension (high blood pressure), chronic obstructive pulmonary disease (affects air exchange in the lungs), Parkinson's disease (a slow, progressive nerve disorder), and pneumonia (infection of the lungs). Resident #39's admission (MDS) Minimum Data Set 3.0 assessment, dated 6/23/14, indicated the resident had short/long term memory problems, severely impaired decision making skills and	F 327		

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acute mental changes. The MDS indicated the resident required total staff assistance for (ADLs) Activities of Daily Living, his/her height was 75 inches, and weight of 178 (#) pounds. The MDS indicated the resident received a mechanically altered diet, antibiotic medication 7 days of the look back period and (IV) intravenous medication.

The 6/23/14 (CAA) Care Area Assessment for nutrition indicated the resident required total staff assistance with eating and required honey thickened liquids. The resident currently had aspiration pneumonia (a lung infection potentially caused by inhaling solids into the lungs).

The CAA for hydration indicated the resident required honey thickened liquids, total staff assistance with eating/drinking. The CAA further indicated the resident was at high risk for dehydration and he/she had aspiration pneumonia. The resident experienced a sudden acute illness on top of his/her dementia and severe Parkinson's disease and he/she had a significant deterioration in his/her health status.

The 6/13/14 initial care plan directed the staff to assess the resident for dehydration (change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucous membranes, sunken eyes, constipation, fever, infection and/or electrolyte imbalance), document the findings and notify the physician as needed. The care plan directed the staff to assist the resident with eating/drinking at every meal and offer thickened liquids during cares. The 6/14/14 care plan update for nutrition directed the staff to provide honey thickened liquids, assist the resident with eating and watch him/her for choking and swallowing problems. The care plan instructed the staff to ensure the

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resident sat upright before and after eating/drinking and to keep the resident's (HOB) head of the bed elevated.

The 6/13/14 admission nursing assessment indicated the resident had a pink, moist tongue, clear lung sounds, no cough, no sputum, no swelling and no feeding tube. The assessment indicated the resident received a pureed diet with thickened liquids.

The 6/13/14 physician's order directed the staff to administer Cipro (antibiotic), 500 (mg) milligrams, by mouth, twice daily for 6 days for a diagnosis of pneumonia. The order also directed staff to provide the resident a regular pureed diet.

Review of the medical record revealed no dietary assessment for the resident, from 6/13/14 to 6/24/14, at which time the resident returned to the hospital with the diagnoses of dehydration and pneumonia.

The 6/13/14 at 11:00 AM, nurse's note indicated the resident's lung sounds were clear, his/her skin was warm, pink and dry and the resident's vital signs (temperature, pulse, blood pressure, respirations) all within normal range.

The nurse's notes revealed the following:
6/14/14 at 5:25 PM, the resident ate and drank fluids slowly, and choked easily.
6/16/14 at 4:57 AM, the resident's urine had a foul odor.
6/17/14 at 11:59 PM, resident's urine was tea colored and had a foul odor.
6/18/14 at 12:08 AM, the resident's urine was a dark tea color and had a foul odor.
6/19/14 at 3:12 AM, the resident's urine was amber colored, had a foul odor and the resident

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F 327	Continued From page 49 continued on antibiotics for a diagnosis of pneumonia. The 6/19/14 (UA) Urinary Analysis lab work indicated the resident's urine had a value of greater than 1030 specific gravity (normal range is 1005-1030 and the greater the value, the more concentrated the urine), negative for leukocytes (an indicator of infection) and positive for few bacteria. The 6/19/14 physician's order included a speech consultation and honey thickened liquids. Further review of the nurse's notes indicated the following: 6/20/14 at 2:46 AM, the resident's urine was a dark yellow color and had a foul odor. 6/21/14 at 3:45 PM, the resident had a "raspy" cough, no choking this shift, the resident had taken a small amount of thickened liquids today and the resident's urine was reddish tinged, amber colored with a fair amount of mucous. The note indicated the nurse contacted the physician regarding another matter for the resident, but included no documentation the nurse informed the physician of the resident's "raspy" cough and poor intake. 6/22/14 at 4:20 PM, the resident's lung sounds were coarse (not clear), his/her skin was clammy/warm, and he/she had a temperature of 97 degrees. The note indicated the resident's family member requested the staff notify the physician. The 6/23/14 physician's order directed the staff to obtain a chest x-ray, (CBC) complete blood count and (CMP) complete metabolic profile blood	F 327		

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F 327	Continued From page 50 laboratory work for the resident. The 6/23/14 CMP (a test to monitor and evaluate fluid and electrolyte balance) indicated the resident's sodium level at 150 (normal range 137-145), (BUN) Blood/Urea/Nitrogen (an indicator of inadequate kidney function) level of 29 (normal range 9-20). According to Mosby's manual of Diagnostic and Laboratory Tests, second edition, dehydration tended to concentrate the BUN and cause higher levels). The 6/23/14 physician's order directed the staff to provide a high protein pureed diet with thickened liquids for the resident. Further nurse's notes indicated the following: 6/23/14 at 3:53 PM, the resident choked on a large amount of phlegm (sticky mucous), nursing staff suctioned him/her and notified the physician. 6/24/14 at 1:15 AM, nursing staff applied oxygen per nasal cannula at 2 liters per minute and administered a respiratory treatment to the resident. The note indicated the nurse crushed and administered medications with thickened liquids. The note further indicated the resident was unable to clear his/her throat of phlegm and the staff suctioned him/her. 6/24/14 at 5:34 PM, the resident was unable to swallow medications this morning, was lethargic (abnormal lack of energy) and hard to arouse. The note indicated staff notified the physician and made an appointment for the resident. The note further indicated the resident rested in bed, moaned, and appeared uncomfortable at times. The note stated the staff did not provide the resident fluids due to the resident being unable to swallow. The note further indicated the physician	F 327		

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admitted the resident to the hospital directly from the physician's appointment with diagnoses of dehydration and pneumonia.

The medical record revealed the resident weighed 176.8 # (80.36 kilograms) on 6/11/14, just prior to admission to the facility. The staff did not obtain an admission weight on the resident when admitting him/her to the facility. The basic estimation for fluid needs, based on 30 (cc) cubic centimeters per kilogram, revealed the resident's estimated daily fluid needs at 2410 cc.

Review of the daily fluid intake records from 6/13-6/23/14 revealed:
6/13/14= 710 cc (cubic centimeters)
6/14 = 500 cc
6/15= 375 cc
6/16= 240 cc
6/17 = 360 cc
6/18= 100 cc
6/19=120 cc
6/20= 300 cc
6/21= 445 cc
6/22= 660 cc
6/23= 310 cc
No other documentation of fluids was provided when requested.

The 6/24/14 hospital admission history and physical stated the resident came to the office today because the facility nurses were concerned that he/she was not swallowing and did not have anything to eat or drink today. The document stated the physician was concerned about dehydration, infection and the chest x-ray showed infiltrate (material) in the resident's left lower lobe of the lungs. The document stated the resident had a cough, choked on food and the nurses suctioned him/her several times. The document

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stated the resident's oxygen saturation was 88% (normal range was 90-100%) on room air, his/her skin color was dusky (darker than normal), mucous membranes were extremely dry and he/she had food and debris caked onto the soft palate (separates the roof of the mouth from the back of the mouth). The physician's assessment included the following: (1) dehydration (2) pneumonia, (3) Parkinson's disease exacerbated (irritated), (4) dementia, (5) obstructive uropathy (a condition that blocks the flow of urine), (6) hypernatremia (a greater than normal concentration of sodium in the blood) with sodium of 150. The document stated the plan was to admit the resident to the hospital, start fluids and administer antibiotics. The document stated the physician cautioned the resident's family member about the resident's grave (serious) condition.

The 6/27/14 hospital admission to swing bed history and physical stated the hospital admitted the resident with severe dehydration and bilateral pneumonia. The document indicated the resident's sodium level came down, the resident has been hydrated and his/her cognitive status improved.

On 7/17/14 at 9:40 AM, observation revealed the resident in bed with the HOB elevated approximately 30 degrees. Further observation revealed Nurse L administered medication through the resident's feeding tube. Nurse L provided a 30 cc water flush, 8 oz. of Arginaid (a supplement) mixed with a 12 gram protein drink, then flushed the feeding tube with 30 cc of water.

On 7/21/14 at 11:45 AM, Dietary Manager C verified neither the (RD) Registered Dietician nor he/she had completed a nutritional assessment of the resident, including his/her estimated fluid

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needs, for the initial 6/13/14 admission to the facility.

On 7/21/14 at 2:10 PM, Nurse N stated he/she had called the physician on 6/24/14 in the morning, regarding the resident's choking on phlegm and no food/fluid intake and the resident went to the physician appointment in mid afternoon. He/she stated staff did not monitor the resident's total intake of fluids, including fluids provided during care, during June, and normally do not document intake. He/she stated the staff monitored for signs and symptoms of dehydration and offered fluids with all cares and meals.

On 7/22/14 at 7:30 AM, Administrative Nurse A stated the admitting nurse should initiate the initial care plan interventions related to the current needs of the resident. He/She verified the staff had not updated the care plan with interventions or instructions for the resident's nutritional status, which would indicate he/she was to receive nothing by mouth, had a feeding tube and received tube feedings.

On 7/22/14 at 5:45 PM, Physician O stated the resident had a lot of comorbidities (coexisting diseases) and he/she was unsure if the second admission to the hospital (6/24/14) was a re-occurrence of pneumonia or aspiration. Physician O stated the resident had difficulty clearing secretions due to his/her Parkinson's disease, the resident was alert within 12 hours of re-admission to the hospital on 6/24/14, and verified the physician on call had re-admitted the resident to the hospital with dehydration and pneumonia, but the dehydration was because of the pneumonia. He/she stated the resident's urine may have been concentrated and had foul odor which could mean anything. He/she stated it

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would have been better if the staff had notified the physician of the status of the resident's urine earlier and then the physician could have ordered a UA earlier.

The facility's 8/7/08 Hydration policy stated risk factors included functional impairments that make it difficult for the resident to drink, reach for fluids or communicate needs such as aphasia (abnormal speech function) and/or dysphagia (difficulty swallowing). The policy indicated signs of possible insufficient fluid intake were dry skin and mucous membranes, cracked lips, poor skin turgor, thirst, dry mouth, concentrated urine, lab values such as elevated sodium, BUN, or urine specific gravity, significant weight loss or elevated temperature. The policy further directed the staff to ensure residents on thickened liquids received adequate fluids as they are at a greater risk for dehydration.

The facility's undated Physician Notification policy and procedure stated conditions that warrant staff to notify the physician during normal business hours, within 24 hours of occurrence or the next business day included: signs and symptoms of cold or respiratory infections and signs and symptoms of a (UTI) Urinary Tract Infection. The policy further stated the list was not all inclusive and any time the nurse thought the situation warranted physician notification, they should do so. The policy stated the nurse must make the appropriate assessments of the resident's condition prior to contacting the physician and must document the assessment and the conversation with the physician or clinic personnel in the chart.

The facility failed to monitor and provide sufficient fluid intake to maintain hydration for Resident

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F 327	Continued From page 55 #39, who was re-admitted to the hospital with diagnoses of dehydration and hypernatremia. - Resident # 4's Quarterly (MDS) Minimum Data Set 3.0 assessment, dated 5/21/14, revealed a (BIMS) Brief Interview for Mental Status score of 2, which indicated severe cognitive impairment. The resident required total assistance with his/her (ADLs) Activities of Daily Living and received nectar thickened fluids. The 10/23/13 Dehydration/fluid Maintenance (CAA) Care Area Assessment revealed the resident had a diagnosis of Congestive Heart Failure (a condition with low heart output and the body becomes congested with fluid) and was administered a daily diuretic. The 3/5/14 care plan for nutrition revealed a decline in status and instructed staff to provide nectar thickened fluids and thicken the liquids just prior to serving. The resident low fluid intake care plan directed staff to offer fluids each time he/she worked with the resident and at meal times. The 7/14/14 physician orders instructed staff to provide Gatorade (a brand of noncarbonated sports drink designed to supply the body with carbohydrates and replace fluids and sodium lost during exertion), no milk products, and nectar consistency fluids. On 8/5/14 at 12:55 PM, observation revealed the staff served the resident water thickened to pudding consistency. On 8/6/14 at 7:49 AM, observed the staff, serve the resident water thickened to pudding	F 327		

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F 327	Continued From page 56 consistency. On 8/7/14 at 4:58 PM, Administrative Nurse A verified the physician order the resident ' s liquids to be thickened to a nectar consistency. The facility failed to thicken Resident #4 's water to nectar consistency at meal time.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on	F 329		

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observation, interview and record review the facility failed to monitor and provide treatment to ensure healthy bowel elimination for 1 of 5 residents reviewed for medication regimen. (#34)

Findings included:

- Resident #34's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 5/14/14, indicated the resident had cognitive impairment with a (BIMS) Brief Interview for Mental Status score of 5, required extensive staff assistance with transfers, dressing, toileting, was occasionally incontinent of bowel, and received scheduled and as needed pain medication, antidepressive and diuretic medications 7 days of the look back period.

The 5/21/14 care plan for medication directed the staff to assess the resident and record effectiveness of medications, monitor and report signs of sedation, hypotension, and complaints of constipation symptoms.

Review of the medical record revealed the resident received the following medications which all listed constipation as a side effect:
Aspirin (pain reliever), Lasix (diuretic), Sertraline (antidepressive), Risperdal (antipsychotic), Neurontin (an anticonvulsant), and Simvastatin (cholesterol lowering medication).

The medical record revealed the staff documented no bowel movements, for the resident, during the following dates:
(1) 7/14/14 through 7/20/14 (7 consecutive days). The record revealed no documentation that the staff provided bowel elimination interventions or assessed the resident for bowel sounds.
(2) 7/24/14 through 7/31/14 (8 consecutive

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days). The record revealed, on 7/28/14 (5th day), the staff provided prune or apple juice as an intervention, without results. The staff provided (MOM) Milk of Magnesia (laxative) on 7/30/14 (7th day), without results.

On 8/5/14 at 12:33 PM, observation revealed the resident seated at the dining table, fiddling with his/her clothing, with a slightly confused expression on his/her face.

On 8/6/14 at 7:54 AM, observation revealed the resident ambulated with the staff to the dining room and the staff assisted him/her to sit in a dining chair. Further observation revealed Nurse J administered, to the resident, 5 medications, and the resident took the pills all at one time without problems.

On 8/6/14 at 2:56 PM, Nurse Aide P stated the staff documented (BM) bowel movements in the computer. He/she stated, in June, the resident sometimes toileted independently and sometimes he/she was incontinent. Nurse Aide P stated the resident now required more assistance with toileting and transfers and the staff notified the nurse if the resident had no BM in 3 days.

On 8/6/14 at 3:02 PM, Nurse J stated the staff are to give prune juice on the 4th day without a BM, and (MOM) Milk of Magnesia (laxative) per the bowel program on the 5th day. Nurse J verified the (MAR) Medication Administration Record indicated the staff provided no, (PRN) as needed, bowel elimination interventions from 7/13/14 to 7/20/14. He/she verified the staff provided no PRN bowel elimination interventions from 7/23/14 until 7/28/14 (day 5), without result, and on 7/30/14 (day 7) the staff administered MOM, but no results were documented until 7/31/14.

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F 329	Continued From page 59 On 8/7/14 at 2:55 PM, Nurse N stated the facility computer program alerts the staff, on day 4, if the resident had no documented BM for 3 days. Nurse J stated, if alerted, the nurses are to check bowel sounds, give prune juice, and follow with MOM the next day if the resident has not had a BM. He/she stated if the nurse administers an enema on the 3rd day post alert, he/she would also notify the physician. On 8/7/14 at 4:45 PM, Administrative Nurse A stated the nurses are to implement the bowel protocol on the resident's fourth day without a BM. The facility's 2010 Bowel Program directed the staff to implement the following bowel regimen after 3 days without a BM: Day #1 (day 4 without BM) - offer 120 (cc) cubic centimeters prune or grape juice. Day #2 - Give 30 cc (MOM) Milk of Magnesia in the morning, if no BM the day before, and administer a dulcolax suppository in the evening if still no BM. Day #3 - enema in the morning, if bowels have not moved the day before, and if no results, contact the physician. The facility failed to monitor and provide interventions to ensure adequate bowel elimination for Resident #34.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

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F 371	Continued From page 60 under sanitary conditions	F 371		

This Requirement is not met as evidenced by:
The facility had a census of 34 residents. The sample included 17 residents. Based on observations and interview the facility failed to serve food under sanitary conditions for 1 of the 4 onsite days in one of one dining rooms for the 34 residents residing in the facility.

Findings included:

- On 8/6/14 at 8:08 AM, observation revealed Nurse Aide T approached the resident ' s assisted dining room table and sat down beside Resident #4, to assist him/her to eat. Nurse Aide T handled empty sugar packs and the silverware the prior aide had held, rubbed the wooden armrests of the chair he/she was seated in, and then assisted the resident by tearing the resident ' s toast in half with his/her hands. Further observation revealed Nurse Aide T did not wash his/her hands or use hand gel at any time while he/she was in the dining room.

On 8/7/14 at 1:30 PM, Nurse Aide T stated an aide should wash his/her hands before and after soiling his/her hands, and between residents when providing assistance. Nurse Aide T stated this included helping the residents in the dining room and also stated he/she did not realize he/she had touched the resident ' s toast with his/her bare hands.

On 8/7/14 at 4:58 PM, Administrative Nurse A verified the nurse aides needed to do proper

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F 371	Continued From page 61 hand washing prior to assisting a resident to eat or providing assistance for the residents. Upon request the facility had no policy for the nursing staff to wash his/her hands prior to assisting a resident to eat. The facility failed to ensure the nursing staff did proper hand washing prior to assisting Resident #4 to eat.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431		

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F 431	Continued From page 62 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on observation, record review and interview, the facility failed to ensure stock medications were not outdated for the 34 residents, who resided in the facility, in 1 of 1 medication rooms and 1 of 2 medication carts. The facility failed to ensure the freezers were maintained and defrosted to ensure proper cooling in 1 of 1 medication rooms. Findings included: - On 8/4/14 at 9:33 AM, during the initial tour, observation of the medication room revealed one bottle of stock Aspirin (pain, fever medication), 325 (mg) milligrams, with an expiration date of 3/2012. Also during the initial tour, observation revealed a stock bottle of Calcium, 600 mg, with Vitamin D (a vitamin supplement) with an expiration date of 5/14 and stock Aspirin, 81 mg, with expiration date 4/14 on the north hall medication cart. On 8/4/14 at 9:34 AM, Nurse I verified the expiration date on the Aspirin bottle. On 8/4/14 at 9:55 AM, Nurse J verified the expiration dates on the Calcium and Aspirin bottles. On 8/5/14 at 3:12 PM, Administrative Nurse A verified the nurses were to check the resident's	F 431		

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F 431	Continued From page 63 medications and the stock medications for expiration dates when giving the medication. The facility did not provide a policy for monitoring the expiration of medications. The facility failed to ensure the stock medications were not outdated. The failure placed the resident's at a potential for receiving outdated medications. - On 8/4/14 at 9:33 AM, during the initial tour, observation of the medication room revealed the freezer compartment of the refrigerator had approximately 2 inches of ice build-up on the bottom shelf. On 8/5/14 at 7:20 AM, observation revealed the 2 inch ice build-up remained in the freezer of the refrigerator in the medication room. On 8/5/14 at 7:20 AM, Nurse J verified the freezer in the refrigerator needed to be defrosted. Nurse J stated he/she was unsure if anyone was responsible for defrosting the freezer. On 8/5/14 at 3:12 PM, Administrative Nurse A stated he/she was unsure if any specific staff was responsible for defrosting the freezer in the refrigerator in the medication room. Although requested, the facility failed to provide a policy for defrosting the freezer compartment of the refrigerator in the medication room. The facility failed to maintain and defrost the freezer in the medication room.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 64 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility had a census of 34 residents. The sample included 17 residents. Based on	F 441		

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observation, record review, and interview, the facility failed to provide a safe, sanitary environment to prevent the development and transmission of disease and infection by improperly storing nasal cannulas for 3 of the 9 residents who received oxygen (#14, #33, and #37) and Resident #14's nebulizer (respiratory treatment mask).
The facility failed to dispose of contaminated waste to help minimize the potential transmission of infections to the community, by not securely locking the red bag dumpster.
The facility failed to disinfect the whirlpool tub properly by not adding the proper amount of disinfectant when cleaning the whirlpool.

Findings included:

- On 8/4/14 at 4:00 PM, observation revealed Resident # 14's nasal cannula (nose piece of the oxygen tubing) lying on the resident's bed, his/her nebulizer mask next to the nebulizer machine, and neither in a protective covering.

On 8/5/14 at 7:50 AM, observation revealed Residents #33 and #37's nasal cannula on the bedside table or draped across the resident's bed and not in a protective covering, and Resident #14's nebulizer mask, uncovered, and lying beside the nebulizer machine.

On 8/6/14 at 4:33 PM, observation revealed Residents #14 and #33's nasal cannula lying on the resident's bed and not in a protective covering, Resident #37's nasal cannula draped over the bedside table in the resident's room, Resident #14's nebulizer mask, uncovered, on a shelf below the nebulizer machine.

On 8/7/14 at 7:50 AM, observation revealed

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Resident #14 and #33's nasal cannulas were on the floor in front of the oxygen concentrator. Observation also revealed Resident #37's nasal cannula draped over the oxygen concentrator in his/her room and not bagged.

On 8/7/14 at 7:52 AM, Administrative Nurse A verified the staff should place the residents' nasal cannula in plastic bags, when the residents' oxygen was not in use, to prevent contamination of the nasal cannula.

Upon request the facility provided no policy for the storage of the residents' nasal cannulas or nebulizer masks when not in use.

The facility failed to store nasal cannulas and/or nebulizer masks in a manner that prevents the development and transmission of disease and infection for Resident # 14, #33, and #37.

- On 8/6/14 at 10:15 AM, observation revealed the facility had one dumpster, outside the facility on the south side, labeled red bags only (indicating biohazardous waste) and was not securely locked.

On 8/7/14 at 8:3 AM, Maintenance Staff E stated the red bag dumpster was used to dispose of the red bagged items from the facility. Maintenance Staff E stated the same trash company picked up the red bag items, but used a different trash truck. Maintenance Staff E verified the red bag dumpster was not secured in any way, and posed a concern for spread of infection.

On 8/7/14 at 8:35 AM, Administrative Nurse A verified the aides put the red trash bags in the red bag dumpster outside the facility, and he/she had not thought of securing the dumpster.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 67 On 8/7/14 at 8:38 AM, Housekeeping Staff F stated, if a resident was in isolation, the housekeeping department placed the red trash bags, from the isolation room, in the red bag dumpster. On 8/7/14 at 9:12 AM, Nurse Aide G stated the resident whose trash was in a red bag was disposed of in the red bag dumpster. The 4/2000 Kansas Department of Health and Environment, Bureau of Waste Management, stated medical waste must be placed in containers, which are closable, constructed to contain all contents and to prevent leakage of fluids and closed prior to removal. Upon request the facility provided no policy for disposal of red bags in the red bag dumpster and the securing of the dumpster. The facility failed to properly secure the red bag dumpster, which contained the isolation trash and/or any bodily fluid, or a contaminated item, to minimize the potential transmission of infections. - On 8/6/14 at 11:20 AM, observation revealed Nurse Aide S demonstrated the process of cleaning the whirlpool, with written instructions posted on the wall. Nurse Aide S drained the whirlpool, filled the foot well of the whirlpool and poured in 2 ounces, of Classic Whirlpool Disinfectant, using a medication cup for measurement, or 2 capfuls of the disinfectant with the water. Nurse Aide S used a household brush to scrub the sides of the whirlpool, left the solution to sit for 1 minute, rotated the whirlpool jets and disassembled the jet assembly, which	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E183	A. BUILDING _____ B. WING _____	08/19/2014

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F 441	Continued From page 68 sat in the water solution for 3 minutes. The Classic Whirlpool Disinfectant instructions stated to drain the water fill to cover the intake valve, and add 2 ounces of cleaner for each gallon of water added. The instructions further stated to start the whirlpool pump to circulate the water, and rinse. The disinfectant cleaner stated to sanitize the surface of the whirlpool, wipe the surface with diluted solution and allow to remain on for 30 seconds and air dry. The disinfectant instructions indicated to add 2 ounces of the solution to each gallon of water and allow to air dry on the surface of the whirlpool for 10 minutes. On 8/6/14 at 11:20 AM, Nurse Aide S stated he/she cleaned the whirlpool as stated with the directions on the wall, and waited 1 minute after adding the 2 ounces of the disinfectant in the foot well, and filled the whirlpool with several gallons of water and then waited additional 3 minutes. On 8/7/14 at 4:58 PM, Administrative Nurse A stated the facility had no procedure for cleaning the whirlpool and the directions on the wall in the whirlpool room were probably from the old whirlpool. Administrative Nurse A stated he/she didn ' t think anyone knew the directions to clean the new whirlpool or if the posted cleaning directions were accurate. On 8/11/14 at 8:10 AM, Administrative Nurse A stated the whirlpool cleaning instructions, hanging in the whirlpool room, were incorrect and the instructions on the bottle of the whirlpool disinfectant cleaner stated the staff should be adding 2 ounces of cleaner per gallon of water to disinfect the whirlpool. The facility failed to disinfect the whirlpool tub	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 69 properly by not adding the proper amount of disinfectant when cleaning the whirlpool and provide a safe, sanitary environment to prevent the spread of disease and infection.	F 441		